FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037267

Facility Name: Country Club Terrace

Address: 7800 West 183rd Street (Number) Country Club Hills (City) 60478 (Zip Code)

County: Cook

Telephone Number: (708) 798-616 **Fax #** (708) 7980031

IDPA ID Number: 36-2171735

Date of Initial License for Current Owners: 8/15/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kevin J. Morrissey **Telephone Number:** (708) 342-5200

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/01 to 6/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 12/20/02 (Date)
(Type or Print Name) Wayne Kottmeyer
(Title) Executive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	5,412			5,412	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,412			5,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.67%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 3/11/91

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 9/12/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	21,746		960	22,706		22,706		22,706			1
2	Food Purchase		26,232		26,232		26,232	63	26,295			2
3	Housekeeping		13,845	12,335	26,180		26,180	1,929	28,109			3
4	Laundry		1,692		1,692		1,692	11	1,703			4
5	Heat and Other Utilities			10,122	10,122		10,122	2,592	12,714			5
6	Maintenance			4,521	4,521		4,521	15,060	19,581			6
7	Other (specify):*											7
8	**TOTAL General Services**	21,746	41,769	27,938	91,453		91,453	19,655	111,108			8
	B. Health Care and Programs											
9	Medical Director		1,869	3,600	5,469		5,469	1,222	6,691			9
10	Nursing and Medical Records	245,071	7,238	9,073	261,382		261,382	7,774	269,156			10
10a	Therapy			384	384		384		384			10a
11	Activities		2,431		2,431		2,431	92	2,523			11
12	Social Services	52,960			52,960		52,960	4,833	57,793			12
13	Nurse Aide Training							2,155	2,155			13
14	Program Transportation		1,820		1,820		1,820	5,309	7,129			14
15	Other (specify):* Dental & Optometrist			57	57		57	7,937	7,994			15
16	**TOTAL Health Care and Programs**	298,031	13,358	13,114	324,503		324,503	29,322	353,825			16
	C. General Administration											
17	Administrative	31,875			31,875		31,875	7,216	39,091			17
18	Directors Fees											18
19	Professional Services							5,212	5,212			19
20	Dues, Fees, Subscriptions & Promotions			100	100		100	1,910	2,010			20
21	Clerical & General Office Expenses		875	6,650	7,525		7,525	17,222	24,747			21
22	Employee Benefits & Payroll Taxes							90,960	90,960			22
23	Inservice Training & Education											23
24	Travel and Seminar			105	105		105	608	713			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			270	270		270	4,803	5,073			26
27	Other (specify):*			1,543	1,543		1,543	1,588	3,131			27
28	**TOTAL General Administration**	31,875	875	8,668	41,418		41,418	129,519	170,937			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	351,652	56,002	49,720	457,374		457,374	178,496	635,870			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Country Club Terrace #0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,708	5,708		5,708	2,202	7,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			759	759		759	1,885	2,644			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			57,660	57,660		57,660	2,248	59,908			34
35	Rent-Equipment & Vehicles			531	531		531	884	1,415			35
36	Other (specify):*			2,060	2,060		2,060	318	2,378			36
37	**TOTAL Ownership**			66,718	66,718		66,718	7,537	74,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		762		762		762	8	770			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,104	46,104		46,104		46,104			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		762	46,104	46,866		46,866	8	46,874			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	351,652	56,764	162,542	570,958		570,958	186,041	756,999			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	1,711	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	53	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,764		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,764		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Country Club Terrace

ID# 0037267

Report Period Beginning: 7/01/01

Ending: 6/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	1,711	0	0	0	0	0	0	0	0	0	0	1,711	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	1,711	0	0	0	0	0	0	0	0	0	0	1,711	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	53	0	0	0	0	0	0	0	0	0	0	53	27
28	**TOTAL General Administration**	53	0	0	0	0	0	0	0	0	0	0	53	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,764	0	0	0	0	0	0	0	0	0	0	1,764	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,764	0	0	0	0	0	0	0	0	0	0	1,764	45

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NOT APPLICABLE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V				NOT APPLICABLE				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	NOT APPLICABLE										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Coffee & Supplies #200	Overhead Salaries	1,761,908	12	$ 2,165	$	49,299	$ 61	1
2	2	Food Purchases #600	Contact Hours	390,122	8	373		2,415	2	2
3	3	Housekeeping Staff #250	Contact Hours	830	12	8,356	8,356	41	418	3
4	3	Housekeeping Consult #200	Tinley Park Wages	2,518,343	12	88,800		38,902	1,372	4
5	3	Household Supplies #200	Tinley Park Wages	2,518,343	12	8,310		38,902	128	5
6	3	Paper Products #250	Contact Hours	830	12	224		41	11	6
7	4	Uniform Rental #250	Contact Hours	830	12	229		41	11	7
8	5	Electric, Heat & Other #100	Contact Hours	5,975	12	342		299	17	8
9	5	Electric, Heat & Other #200	Weighted TP Salaries	5,529,871	12	117,308		38,902	825	9
10	5	Electic, Heat & Other #300	Contact Hours	11,615	12	35,009		581	1,750	10
11	6	Maintenance Staff #200	Contact Hours	314	12	3,931	3,931	16	197	11
12	6	Maintenance Staff #300	Contact Hours	11,615	12	180,531	180,531	581	9,027	12
13	6	Maintenance Consultants #200	Tinley Park Wages	2,518,343	12	9,756		38,902	151	13
14	6	Maintenance Consultants #300	Weighted Client Hours	1,846,689	12	5,530		140,160	420	14
15	6	Maintenance Supplies #200	Weighted TP Salaries	5,529,871	12	244		38,902	2	15
16	6	Maintenance Supplies #300	Contact Hours	11,615	12	5,123		581	256	16
17	6	Maintenance Services #200	Weighted TP Salaries	5,529,871	12	13,193		38,902	93	17
18	6	Maintenance Services #300	Contact Hours	11,615	12	5,546		582	278	18
19	6	Maintenance Services #300	Direct	1	1	4,337		1	4,337	19
20	6	Maintenance Other #105	Overhead Salaries	1,761,908	12	670		49,299	19	20
21	6	Maintenance Other #200	Tinley Park Wages	2,518,343	12	15,129		38,902	234	21
22	6	Maintenance Other #300	Contact Hours	11,615	12	724		582	36	22
23	6	Carpet Cleaning Fees #600	Contact Hours	390,122	8	1,638		2,415	10	23
24	9	Medical Director Consultant #501	Weighted Client Hours	1,846,689	12	12,500		140,160	949	24
25	TOTALS					$ 519,969	$ 192,818		$ 20,604	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	9	Pharmacist Consultant	Weighted Client Hours	1,846,689	12	$ 3,600	$	140,160	$ 273	1
2	10	Medical Supplies #501	Contact Hours	12,211	11	15,325		378	474	2
3	10	Medical Supplies #600	Contact Hours	390,122	8	560		2,415	3	3
4	10	Nursing Staff #501	Contact Hours	12,211	11	235,867	235,867	378	7,297	4
5	11	Recreation & Prgm #108	Contact Hours	9,872	9	56		153	1	5
6	11	Atrium Supplies #200	Overhead Salaries	1,761,908	12	3,265		49,299	91	6
7	12	Ministry Staff #104	Contact Hours	2,080	12	31,068	31,068	104	1,553	7
8	12	Social Service Staff #500	Contact Hours	17,547	9	247,597	247,597	61	865	8
9	12	Residential Staff #600	Contact Hours	25,689	8	390,122	390,122	159	2,415	9
10	13	Staff Training Salary #107	Contact Hours	520	12	14,741	14,741	26	737	10
11	13	Staff Training Supplies #107	Contact Hours	1,753	12	1,835		88	92	11
12	13	Consultants/Staff Trng #107	Contact Hours	1,753	12	26,511		88	1,326	12
13	14	Vehicle UpKeep Salaries #325	Mileage	780,188	12	28,379	28,379	26,187	953	13
14	14	Vehicle Gas & Maintenance #325	Mileage	780,188	12	113,130		26,187	3,797	14
15	14	Vehicle Insurance #100	Contact Hours	5,975	12	814		299	41	15
16	14	Vehicle Insurance #102	Overhead Salaries	1,761,908	12	5,795		49,299	162	16
17	14	Vehicle Insurance #300	Contact Hours	11,615	12	5,391		581	270	17
18	14	Staff Transportation #100	Contact Hours	5,975	12	12		299	1	18
19	14	Staff Transportation #102	Contact Hours	8,138	12	134		407	7	19
20	14	Staff Transportation #103	Contact Hours	4,973	12	176		249	9	20
21	14	Staff Transportation #105	Contact Hours	414	12	177		21	9	21
22	14	Staff Transportation #107	Contact Hours	1,753	12	33		88	2	22
23	14	Staff Transportation #108	Contact Hours	9,872	9	662		153	10	23
24	14	Staff Transportation #300	Contact Hours	11,615	12	215		581	11	24
25	TOTALS					$ 1,125,464	$ 947,774		$ 20,399	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Staff Transportation #500	Contact Hours	17,547	9	$ 3,056	$	61	$ 11	1
2	14	Staff Transportation #501	Contact Hours	12,211	11	781		378	24	2
3	14	Staff Transportation #600	Contact Hours	25,689	8	298		159	2	3
4	15	Psychological Staff #108	Contact Hours	9,872	9	151,605	151,605	153	2,352	4
5	15	Psychiatric Consultants #108	DD Clients	59,932	7	44,883		5,840	4,374	5
6	15	Quality Assurance Staff #110	Contact Hours	1,066	12	24,225	24,225	53	1,211	6
7	17	Executive Director Staff #100	Contact Hours	2,080	12	144,318	144,318	104	7,216	7
8	19	Legal Fees #100	Contact Hours	5,975	12	76,536		299	3,827	8
9	19	Audit Fees #102	Weighted Client Hours	1,846,689	12	11,000		140,160	835	9
10	19	Executive Consultants #100	Weighted Client Hours	1,846,689	12	3,900		140,160	296	10
11	19	Computer Consultants #102	Contact Hours	8,138	12	1,309		407	65	11
12	19	Outside Secretarial #103	Weighted Client Hours	1,846,689	12	2,495		140,160	189	12
13	20	Subscriptions #100	Contact Hours	5,975	12	17		299	1	13
14	20	Subscriptions #501	Contact Hours	12,211	11	108		378	3	14
15	20	Professional Memberships #100	Contact Hours	5,975	12	3,030		299	151	15
16	20	Professional Memberships #100	Direct Revenue	14,410,090	12	10,394		818,399	590	16
17	20	Professional Memberships #107	Contact Hours	1,753	12	207		88	10	17
18	20	Printing #100	Contact Hours	5,975	12	166		299	8	18
19	20	Postage & Shipping #105	Overhead Salaries	1,761,908	12	13,100		49,299	367	19
20	20	Permits & Fees #105	Overhead Salaries	1,761,908	12	499		49,299	14	20
21	20	Advertising #103	Contact Hours	4,973	12	15,320		249	766	21
22	21	Excecutive Staff #100	Contact Hours	3,895	12	45,608	45,608	195	2,280	22
23	21	Finance Staff #102	Contact Hours	8,138	12	159,221	159,221	407	7,961	23
24	21	Human Resource Staff #103	Contact Hours	4,973	12	94,161	94,161	249	4,708	24
25	TOTALS					$ 806,237	$ 619,138		$ 37,261	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Purchasing Staff #105	Contact Hours	414	12	$ 6,109	$ 6,109	21	$ 305	1
2	21	Office Supplies #100	Contact Hours	5,975	12	1,411		299	71	2
3	21	Office Supplies #102	Contact Hours	8,138	12	7,817		407	391	3
4	21	Office Supplies #103	Contact Hours	4,973	12	1,970		249	99	4
5	21	Office Supplies #104	Contact Hours	2,080	12	129		104	6	5
6	21	Office Supplies #105	Contact Hours	414	12	19		21	1	6
7	21	Copier/Fax Supplies #105	Overhead Salaries	1,761,908	12	7,997		49,299	224	7
8	21	Office Supplies #108	Contact Hours	9,872	9	68		153	1	8
9	21	Client Record Supplies #110	Contact Hours	1,066	12	1,071		53	54	9
10	21	Office Supplies #300	Contact Hours	11,615	12	325		581	16	10
11	21	Office Supplies #500	Contact Hours	17,547	10	271		61	1	11
12	21	Office Supplies #501	Contact Hours	12,211	11	623		378	19	12
13	21	Office Supplies #600	Contact Hours	25,689	8	335		159	2	13
14	21	Telephone/Cell #100	Contact Hours	5,975	12	3,666		299	183	14
15	21	Telephone #103	Contact Hours	4,973	12	1,272		249	64	15
16	21	Telephone #200	Tinley Park Wages	2,518,343	12	29,082		38,902	449	16
17	21	Cell Phone #300	Contact Hours	11,615	12	267		581	13	17
18	21	Cell Phone #501	Contact Hours	12,211	11	763		378	24	18
19	21	Cell Phone #600	Contact Hours	25,689	8	14,387		159	89	19
20	21	Page-Net #100	Overhead Salaries	1,761,908	12	4,518		49,299	126	20
21	21	Cable TV #100	Contact Hours	5,975	12	25		299	1	21
22	21	Cable, Internet, ISDN #200	Overhead Salaries	1,761,908	12	4,787		49,299	134	22
23	22	Sisters FICA #104	Contact Hours	2,080	12	2,275		104	114	23
24	22	Christmas Gifts #105	Total Salary	8,804,908	12	500		401,148	23	24
25	TOTALS					$ 89,687	$ 6,109		$ 2,410	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits #120	Total Salary	8,804,908	12	$ 1,993,497	$	401,148	$ 90,823	1
2	24	Conventions & Meetings #100	Contact Hours	5,975	12	11,289		299	564	2
3	24	Conventions & Meetings #102	Contact Hours	8,138	12	614		407	31	3
4	24	Conventions & Meetings #501	Contact Hours	12,211	11	409		378	13	4
5	26	Property & Liability Ins #102	Total Salary	8,804,908	12	98,107		401,148	4,470	5
6	26	Flood Insurance #200	Tinley Park Wages	2,518,343	12	21,575		38,902	333	6
7	27	Board Related Expense #100	Total Salary	8,804,908	12	4,037		401,148	184	7
8	27	Corporate Mtg #100	Total Salary	8,804,908	12	12,512		401,148	570	8
9	27	Open House Expense #100	Total Salary	8,804,908	12	6,003		401,148	273	9
10	27	Bank Fees #102	Contact Hours	8,138	12	2,003		407	100	10
11	27	Illinois State Police #103	Contact Hours	4,973	12	2,040		249	102	11
12	27	ID Tags #103	Contact Hours	4,973	12	234		249	12	12
13	27	Memorials #104	Contact Hours	2,080	12	297		104	15	13
14	27	Bad Debt Expense #600	Contact Hours	25,689	8	8,556		159	53	14
15	27	Use of Restricted Funds #600	Contact Hours	25,689	8	4,047		159	25	15
16	27	Miscellaneous Expense #100	Contact Hours	5,975	12	1,313		299	66	16
17	27	Miscellaneous Expense #102	Contact Hours	8,138	12	3,573		407	179	17
18	27	Miscellaneous Expense #103	Contact Hours	4,973	12	41		249	2	18
19	27	Miscellaneous Expense #300	Contact Hours	11,615	12	14		581	1	19
20	27	Miscellaneous Expense #500	Contact Hours	17,547	12	158		61	1	20
21	27	Miscellaneous Expense #600	Contact Hours	25,689	8	876		159	5	21
22	30	Depreciation - Auto #100	Contact Hours	5,975	12	5,094		299	255	22
23	30	Depreciation - Auto #102	Campus Salary	3,459,994	12	6,661		49,299	95	23
24	30	Depreciation - Computer	Client Hrs/Direct Salary	9,275,876	12	17,534		494,228	934	24
25	TOTALS					$ 2,200,484	$		$ 99,106	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Phone Number: ((708) 342-5200
Fax Number: ((708) 342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation - Other	Client Hrs/Direct Salary	9,275,876	12	$ 17,225	$	494,228	$ 918	1
2	32	SCIF Interest #100	Direct Revenue	14,410,090	12	32,730		818,399	1,859	2
3	32	Auto Interest #102	Campus Salary	3,459,994	12	1,859		49,299	26	3
4	34	Rental Expense #100	Contact Hours	5,975	12	8,980		299	449	4
5	34	Rental Expense #200	Overhead Salary	1,761,908	12	36,420		49,299	1,019	5
6	34	Rental Expense #300	Campus Salary	11,615	12	15,600		581	780	6
7	35	Copier Lease #105	Overhead Salary	1,761,908	12	30,561		49,299	855	7
8	35	Floor Cover Lease	Tinley Park Wages	2,518,343	12	1,886		38,902	29	8
9	36	Equipment Under $500 #100	Various		12	5,060			306	9
10	36	Equipment Under $500 #200	Wghted Tinley Park Salary	5,529,871	12	38,902		1,654	12	10
11	39	Client Medications #600	Contact Hours	25,689	8	1,282		159	8	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 190,505	$		$ 6,261	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				NOT APPLICABLE								2
3												3
4												4
5												5
	Working Capital											
6												6
7				NOT APPLICABLE								7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11				NOT APPLICABLE								11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Club Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037267

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Aluminum Frame Masonary Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	REFER TO SCHEDULE VIII										11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	REFER TO SCHEDULE VIII						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Related Activities	Dodge Maxivan 2000	2000	$ 22,831	$ 5,708	$ 5,708	$	4	$ 14,269	76
77										77
78										78
79										79
80	TOTALS			$ 22,831	$ 5,708	$ 5,708	$		$ 14,269	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,831	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,708	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,269	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: St. Coletta's of Illinois Foundation

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1991	16		$ 57,660	1	20	3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 57,660 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/01/01
Ending 6/30/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2003	$ 55,020
13.	6/30/2004	$ 57,000
14.	6/30/2005	$ 57,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	NOT APPLICABLE				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			94		94
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		737		737
6	Transportation			2		2
7	Contractual Payments				1,326	1,326
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 833	$ 1,326	$ 2,159
10	SUM OF line 9, col. 1 and 2	(e)	$ 833			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits	NOT APPLICABLE					#VALUE!	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/01/01 **Ending:** 6/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 406,012	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		90,846	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Account Receivables		1,816,451	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 2,313,309	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		110,149	15
16	Equipment, at Historical Cost		1,842,821	16
17	Accumulated Depreciation (book methods)		(1,606,829)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investments & Deposits		26,286	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 372,427	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 2,685,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 301,489	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,246,183	29
30	Accrued Salaries Payable		513,305	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Workers Compensation Payable		285,170	36
37	Unearned Rent		6,080	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 2,352,227	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		223,987	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 223,987	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 2,576,214	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 209,371	$ 109,522	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 209,371	$ 2,685,736	48

***(See instructions.)**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 135,202	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 135,202	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	74,169	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 74,169	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 209,371	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 810,319	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 810,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	8,780	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,780	23
	D. Non-Operating Revenue		
24	Contributions	7,493	24
25	Interest and Other Investment Income***	352	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,845	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,224	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,224	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 831,168	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	111,108	31
32	Health Care	353,825	32
33	General Administration	170,937	33
	B. Capital Expense		
34	Ownership	74,255	34
	C. Ancillary Expense		
35	Special Cost Centers	770	35
36	Provider Participation Fee	46,104	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 756,999	40
41	**Income before Income Taxes (line 30 minus line 40)****	74,169	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 74,169	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses		72	1,613	22.40	3
4	Licensed Practical Nurses		1,232	24,950	20.25	4
5	Nurse Aides & Orderlies		22,062	218,508	9.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		2,283	21,746	9.53	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator		1,044	31,875	30.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		3,120	52,960	16.97	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		29,813	$ 351,652 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	60	$ 960	Line 1 Col 3	35
36	Medical Director	N/A	3,600	Line 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	448	9,073	Line 10 Col 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6	384	Line 10a Col3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental & Optometrist		57	Line 15 Col 3	46
47	Outside Housekeeping		12,335	Line 3 Col 3	47
48	Schedule VIII - Prgm & Other Consultants		14,076		48
49	TOTAL (lines 35 - 48)	514	$ 40,485		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia O'Brien	Administrator		$ 31,875
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,875

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Schedule VIII		
Allocation of Indirect Costs		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,857
Unemployment Compensation Insurance	2,439
FICA Taxes	30,802
Employee Health Insurance	20,500
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,043
Life & LTD Insurance	2,854
Dental Insurance	2,430
Payroll Practice Plan	11,906
403(b) Administrative Expense	105
Other	24
TOTAL (agree to Schedule V, line 22, col.8)	$ 90,960

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	766
Health Care Worker Background Check	
(Indicate # of checks performed)	
Permits & Fees	114
Subcriptions	4
Professional Memberships	751
Printing	8
Postage & Shipping	367
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	713
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 713

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3	NOT APPLICABLE												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/01/01 Ending: 6/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **46,104**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **N/A** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **0** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Mulcahy, Pauritsch, Salvador &Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.